

Supplementary Materials for

***Apolipoprotein-ε4* is associated with higher fecundity in a natural
fertility population**

Benjamin C. Trumble *et al.*

Corresponding author: Benjamin C. Trumble, btrumble@asu.edu; Jonathan Stieglitz, jonathan.stieglitz@iast.fr;
Caleb E. Finch, cefinch@usc.edu; Hillard Kaplan, hkaplan@chapman.edu; Michael Gurven, gurven@anth.ucsb.edu

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Figure S1: STROBE Diagram indicating sample data and sample sizes.

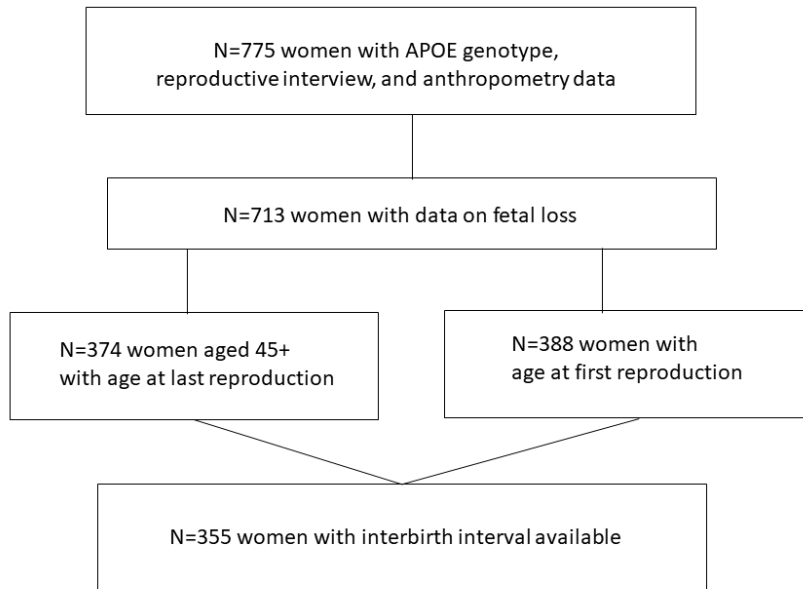


Figure S2: Predicted probability of a single birth event at a particular age, for women carrying two copies of the *APOE-ε4* allele (black), women carrying a single copy of the *APOE-ε4* allele (navy) and women who do not carry the allele (yellow). We observe a substantially increased probability of having a child for women with two copies of the allele, and an increased probability of having a child for women with one copy of the allele, compared with women who do not carry the allele, at all ages, controlling for BMI. The lines plot the posterior mean, and the shaded intervals plot the 95% compatibility region of the posterior interval. The empty circles plot the mean number of births recorded for women at a particular age, colored by the *APOE* genotype.

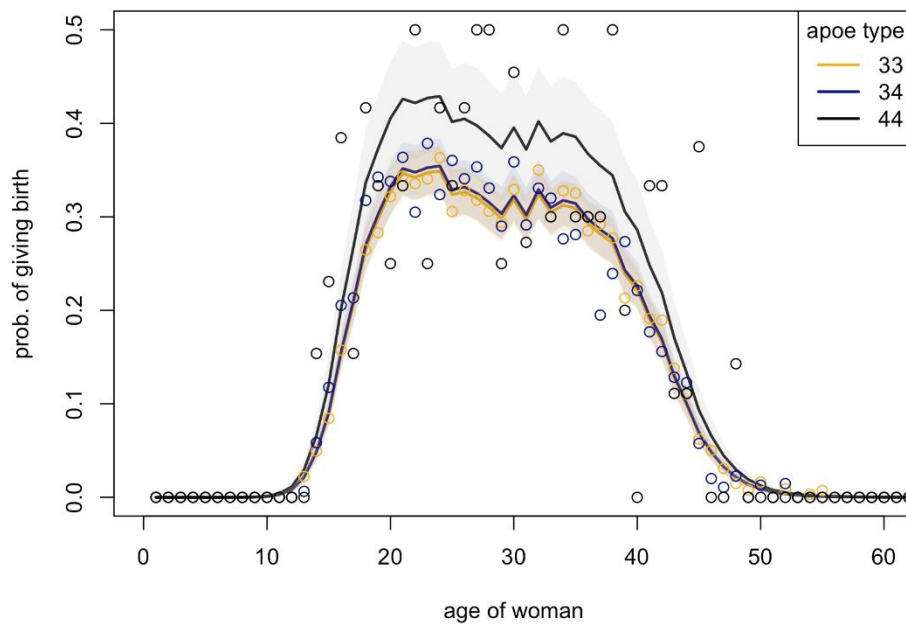


Figure S3: Predicted fetal loss by *APOE* genotype. The first panel uses frequentist statistics, while the second panel represents the Bayesian results

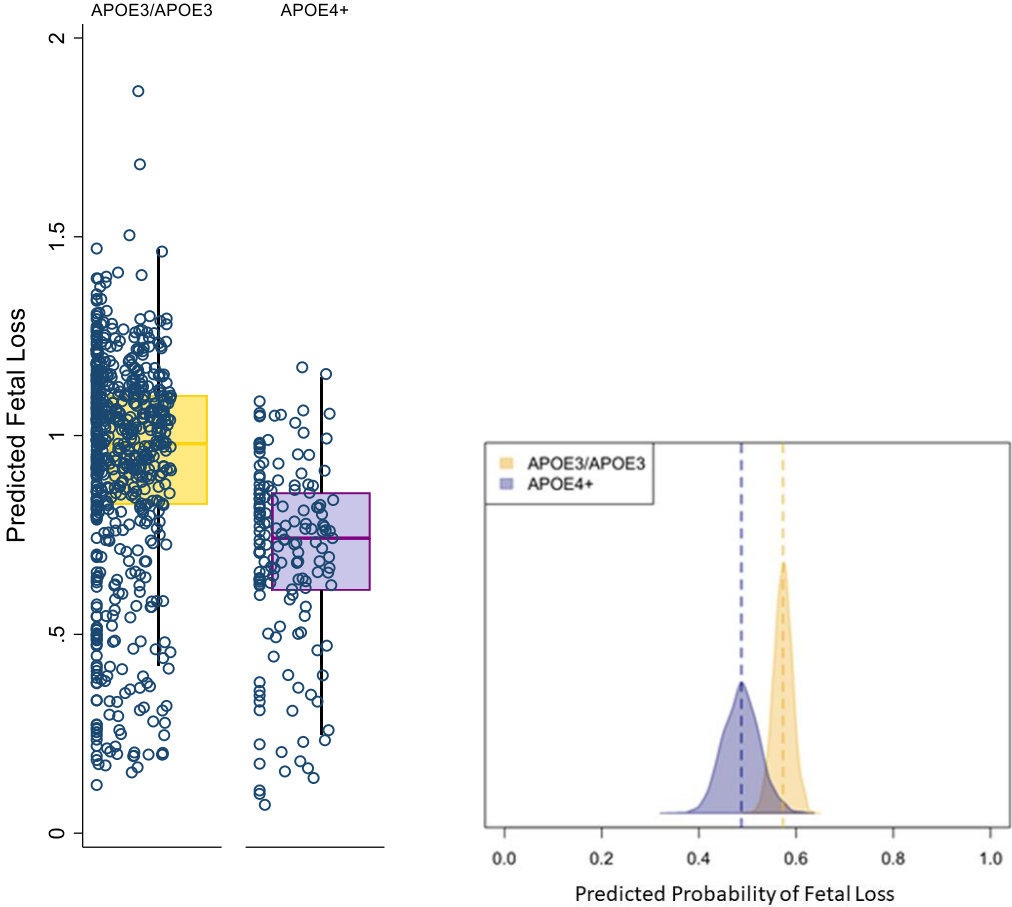


Figure S4: Proportion of APOE-ε4 alleles by age

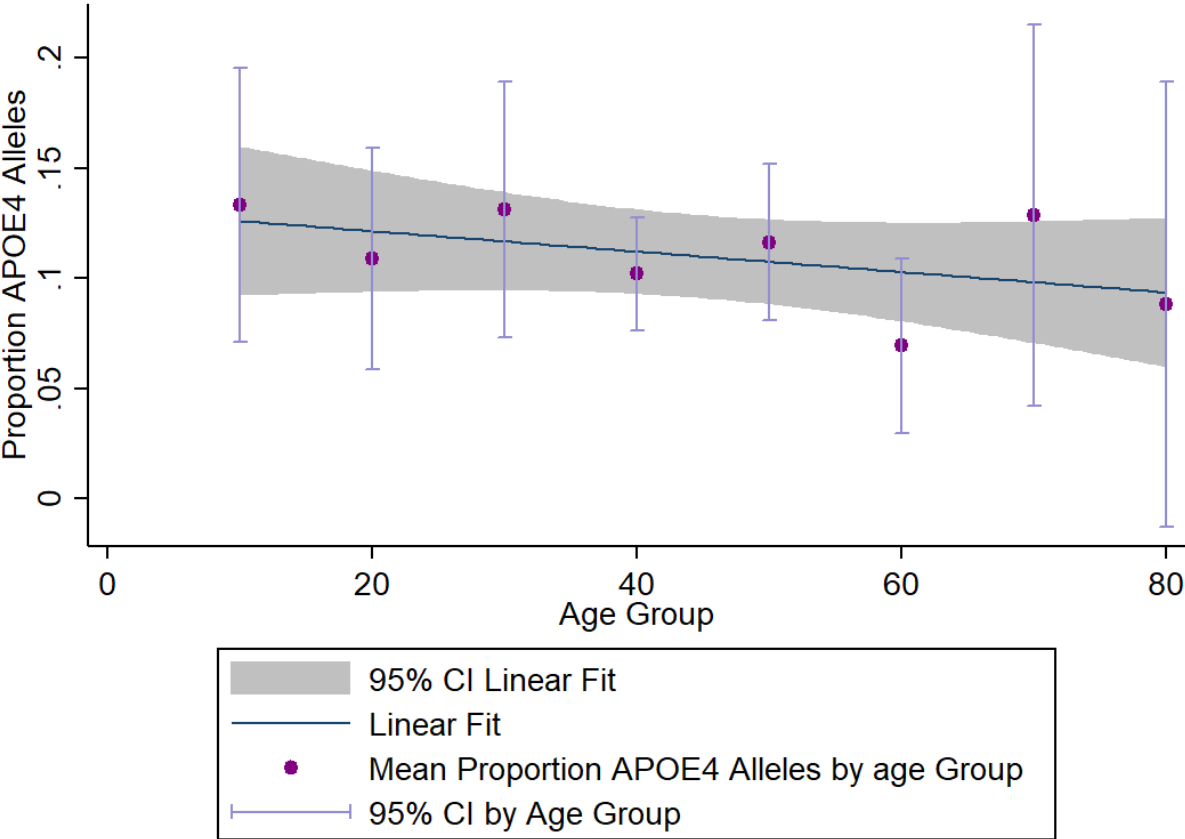


Table S1: Associations between fertility and *APOE-E4* + genotype

	Coefficient	Std Err.	P Value	95%CI	
<i>APOE-ε4+</i>	0.067	0.033	0.033	0.005	0.129
1/Age	-47.375	1.737	<0.001	-50.781	-43.969
BMI	0.007	0.003	0.026	0.001	0.012
Constant	2.023	0.385	<0.001	2.805	3.115

N=795, Pseudo R²=0.209

Table S2: Associations between fertility and *APOE*- $\epsilon 4$ genotypes

	Coefficient	Std Err.	P Value	95% CI	
<i>APOE</i> - $\epsilon 3$ / <i>APOE</i> - $\epsilon 4$	0.056	0.033	0.084	-0.007	0.120
<i>APOE</i> - $\epsilon 4$ / <i>APOE</i> - $\epsilon 4$	0.188	0.097	0.053	-0.002	0.379
1/Age	-47.386	1.738	<0.001	-50.792	-43.980
BMI	0.007	0.003	0.020	0.001	0.013
Constant	2.953	0.079	<0.001	-0.008	0.120

N=795, Pseudo R²= 0.2090

Table S3: *APOE* alleles by age and Hardy-Weinberg Equilibrium

	33	34	44	n	p	pq	q	$(p^2)+2pq+(q^2)$
<20	45	14	1	60	0.75	0.233333	0.016667	1.029444
20-30	62	15	1	78	0.794872	0.192308	0.012821	1.016601
30-40	62	15	3	80	0.775	0.1875	0.0375	0.977031
40-50	213	50	2	265	0.803774	0.188679	0.007547	1.023467
50-60	124	33	2	159	0.779874	0.207547	0.012579	1.023456
60-70	89	10	2	101	0.881188	0.09901	0.019802	0.974904
70-80	27	7	1	35	0.771429	0.2	0.028571	0.995918
80+	14	3	0	17	0.823529	0.176471	0	1.031142
Total	636	147	12	795	0.8	0.184906	0.015094	1.010039

APOE-ε4 and Fetal Loss

Research in high-income industrialized settings have not reported associations between fetal loss and *APOE* isoforms (67, 68), however, pregnant Tsimane women inhabit a more physically demanding environment than urban women, and have far more pregnancies than US women, and have little or no prenatal medical care. Previous studies reported major differences in immune function during pregnancy for US women versus Tsimane (69), and future studies will focus on potential mechanisms related to *APOE-ε4* and immune function during pregnancy and fetal loss.

These data are limited by several factors. First, these are all self reports of fetal loss, and without access to hCG pregnancy tests, the only fetal loss that could be reported would be for women who had missed one or more menses and/or had other pregnancy related symptoms, or who experienced a still birth or heavy bleeding during fetal expulsion. Secondly, we do not have timing on the gestational age at which women experienced fetal loss, and there may be major differences in the cause of fetal loss at 8 weeks versus fetal loss at 30 weeks (70). Combined, these limitations make it difficult to assess associations between the *APOE-ε4* allele and fetal loss, and without more fine-grained data it is not possible to test any potential mechanistic role of the *APOE-ε4* allele in fetal loss.

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